STATE MEDICAID DUR BOARD MEETING

THURSDAY, August 11, 2005
7:00 a.m. to 8:30 a.m.
Cannon Health Building
Room 125

MINUTES

Board Members Present:
Charles M. Arena, M.D.
Derek G. Christensen, R.Ph.
Dominic DeRose, R.Ph.
Karen Gunning, Pharm D.
Colin B. VanOrman, M.D.
Bradford D. Hare, M.D.
Joseph K. Miner, M.D.
Wilhelm T. Lehmann, M.D.
Bradley Pace, PA-C

Board Members Excused:
Lowry Bushnell, M.D.

Dept. of Health/Div. of Health Care Financing Staff Present:
RaeDell Ashley
Merelynn Berrett
Richard Sorenson
Brenda Strain
Suzanne Allgaier
Tim Morley
Nanette Waters
Darlene Benson
Tom Jones, M.D.

Other Individuals Present:
Dan Heincy, Merck
Richard Ensign, Pfizer
Pierre Thoumsin, Amgen
Joseph Yau, VMH
Jason Bott, (?)
Oscar Fuller, CMS
Craig Boody, Lilly
Alan Sloan, Purdue
Tim Smith, Pfizer
Loren Greenway, IHC
Lisa Martin, MHAU
Audrey Ozols, Wyeth

Meeting conducted by: Karen Gunning

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1. Minutes for July 14, 2005 were reviewed, corrected and approved.

2. Business carried forward:

   Utah Chronic Pain Program- Darlene Benson, R.N., Tom Jones, M.D., principles with the program from the Department of Health presented information regarding the program, genesis and mechanics. Defining pain and pain medicine was the first thing done and is based on the American Pain Society protocols. Pain Medicine is the specialty concerned with the prevention, evaluation, diagnosis treatment of painful disorders. Pain is under treated. Primary Care providers have the most difficulty with pain patients. The program

attempts to establish a system that would help the primary care provider with the provision of adequate care for these patients. Research favors a multiple-disciplinary approach. University Pain Clinic is the only chronic pain clinic in the state. The protocol has been well received and is based on the services of a Primary Care Physician (PCP). Specialists must be board certified accredited specialists, American Academy of Pain Medicine and the American Board of Anesthesiology physicians. Patients must be 18 years old or older. Criteria is built in to promote appropriate referral into the program. Patients sign consent agreements. Complete evaluations by the full team of disciplines, Mental Health, Physical Therapists, Pain Specialists, are required. A treatment plan is developed for the PCP which is the road map for the patient's treatment. With the pilot, ER visits, poly-pharmacy, use of multiple specialty physicians, use of radiology and lab, and use of home health and DMEs have all decreased. There has been increased use of PCP, physical therapy, and mental health treatment. Appropriate treatment for other ailments has improved. The program has shown a lot of promise and is only available for chronic pain cases with unrelenting pain lasting 6 months or more.

Darlene entertained questions regarding the referral forms and entry requirements and requested comments and suggestions.

Ventavis - IHC protocol and PA proposal - Ventavis is an inhalation medication to be used in Pulmonary Arterial Hypertension; it is the fourth entry for this class of medication, behind an oral preparation, a subcutaneous infusion preparation, and an intravenous infusion preparation. Proposal was for labeled indications only and not for simultaneous use with any of the other three preparations. The Board requested the IHC protocol before making any recommendations. Karen noted that three of the drugs, epoprostenol, treprostinil and the iloprost, are all prostacyclin derivatives, while the bosentan is an endothelin receptor antagonist, and thus use distinct mechanisms of action. This is the basis for the suggestion that iloprost and bosentan be allowed simultaneous off-label use. The use of iloprost is limited to use with a special delivery system and available through specialty pharmacy arrangements. It was noted that it is not a first line drug and costs are similar among the drugs in this category. Proposal was made to amend the prior criteria presented to read: a) covered for labeled indications, b) not for simultaneous use with epoprostenol or treprostinil, c) simultaneous use with bosetan only under the following situations:

-cannot be stabilized in New York Heart Association Functional Class II with a walking distance of >380 m in the 6-min walk test while on either agent alone for > 3 months, OR;

-were able to walk 350 m in the 6-minute walk test after initiation of prostanoid treatment but eventually declined by >50 m from the best individual value on two consecutive measurements, OR;

-right heart catheterization revealed a low cardiac output at rest despite prostanoid treatment, OR;

-abnormal interventricular septal curvature or enlarged right ventricular surface

Motion made and passed.

Calcium with Vitamin D requirements- Information regarding cost and usage for Vitamin D was presented to the Board. RaeDell notes that the OIG is questioning disagreement between law, policy and coverage for this issue. Discussion resulted in a motion to study the legal issues surrounding payment for these products and return to the Board with that information.

Diphenoxylate w Atropine cumulative limit- Last month the Board requested a GI consult for consideration. Dr. John Fang from the University of Utah Department of Gastroenterology was asked to provide the Board an opinion which was presented to the Board along with patient usage history for the top 11 utilizers of this medication. Dr. Fang notes that diphenoxylate with atropine is for short term usage, two weeks or less. He states that for patients with intractable chronic diarrhea, no more than 8 to 10 tablets daily is reasonable. According to Dr. Fang, this patient would be the exception rather than the rule. Brad made a motion to limit diphenoxylate with atropine combination drugs to 180 tabs in a 30-day period. Karen added that combination therapy with immodium not be allowed. Motion was passed.

Alprazolam/lorazepam & short acting benzodiazepines cumulative limit- Additional information was requested at last month's Board meeting for the number of clients receiving more than 90 tablets per month. Tim presented information from the Data warehouse showing 1,695 patients received more than 90 tablets per month for greater than 4 consecutive months out of 16,587 patients that get greater than 90 tabs per month. Dr. Joseph Yau from Valley Mental Health presented an opinion as to how limiting the quantities of benzodiazepines would affect mental health patients. He expressed the opinion that with a cumulative limit a reduction in dosage of not more than 25% of the total dose be applied no more often than every 2 weeks. Discussion suggested a more gradual interval of a month would be more realistic to avoid seizures and withdrawal reactions. Karen requested inclusion of the entire class of benzodiazepines in whatever limitation is proposed. Long-acting and intermediate-acting benzodiazepines would be classed together. Short-acting ones will be classed separately. She also suggested a finalized proposal be brought to the next meeting for consideration.

Consideration of the next three items on the agenda, (Naglazyme (new agent), gabapentin off label use along with Lyrica, Cymbalta and anti-convulsants, and intradialytic parenteral nutrition) were moved to the next Board meeting.

Next meeting was set for September 8, 2005.

Meeting adjourned.

The DUR Board Prior approval subcommittee convened and considered 5 petitions.